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October 1, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

ASSESSING THE COUNTYWIDE NEED FOR INPATIENT BEDS (ITEM NO. 9, AGENDA OF AUGUST 26, 2014)

On August 26, 2014, the Board directed the Chief Executive Officer (CEO) to establish a capital project for the documented need at the Harbor-UCLA Medical Center campus for a replacement hospital building, and work with the Director of Department of Public Works (DPW) to prepare a schedule for completion of the project within 30 days; and direct the CEO, in collaboration with the Directors of DPW and the Department of Health Services (DHS), to report back in writing within 30 days with: 1) The estimated capital cost to complete the expansions at the LAC+USC medical campus (LAC+USC), and the hospital replacement project at the Harbor-UCLA medical campus (H-UCLA) and the ongoing operating funding requirements; 2) Potential funding sources for the capital construction and ongoing operations resulting from capital projects at each of these facilities; 3) The impact of these capital projects on the existing Maintenance of Effort (MOE) between DHS and the State of California; 4) The impact of the Affordable Care Act (ACA) implementation on utilization rates at all County hospitals; 5) A plan to assess the need for additional inpatient beds Countywide, by bed allocation (e.g., medical/surgical beds, telemetry beds, step down beds, psychiatry beds, etc.) including the Martin Luther King, Jr. Medical Center (MLK) campus service area; and 6) A status report on efforts to establish a trauma center in the East San Gabriel Valley (ESGV).

1. THE ESTIMATED CAPITAL COST TO COMPLETE THE EXPANSIONS AT LAC+USC, AND THE HOSPITAL REPLACEMENT PROJECT AT H-UCLA AND THE ONGOING OPERATING FUNDING REQUIREMENTS

LAC+USC Medical Center

Capital Cost – Given the current uncertainty of the project scope, we estimate that the cost of this project could be in the range of $525 million to $750 million, and it could take approximately

six to eight years to complete planning, design and construction. This is based on the assumption that the proposed inpatient expansion would be located in the existing healing garden area north of the existing Diagnostic and Treatment Building. As directed by the Board (Item No. 15, Agenda of August 26, 2014), DPW is in the process of preparing feasibility studies for the proposed 150-bed inpatient expansion of LAC+USC, including the needed expansion of parking, utilities, and support services. These feasibility studies will determine the adequacy of the current facilities, evaluate options for the most expeditious and cost effective approach to expanding the hospital, and study the current and future medical program for the hospital. The studies will evaluate the extent to which the hospital's existing ancillary services (such as laboratory, pharmacy, radiology, etc.) may need to be expanded or renovated to support the expanded number of patient beds. Various alternatives for the size, location, and constructability for parking, and central plant services will be analyzed. Recommendations will be developed based on these studies and presented for consideration by the Board in the Spring of 2015. This analysis will better define the scope of the proposed expansion, which, in turn, will dictate the budget and schedule.

Operating Costs – Based on current cost structures, DHS estimates an additional cost of approximately $200 million to fund 150 additional beds at LAC+USC, assuming there is no need to build out substantial ancillary infrastructure (e.g., dietary, pharmacy, surgical or diagnostic space). More precise estimates must await final determination as to the number of beds, bed mix (intensive care unit vs. step-down vs. medical/surgical), and ancillary infrastructure required.

Harbor-UCLA Medical Center

Capital Cost – The H-UCLA Master Plan, completed in June 2012, provides a concept of how construction of a new patient tower would be phased and developed over approximately eight to ten years, and estimated the cost of this program to be approximately $2 billion, not including the cost to renovate and repurpose the existing patient tower once it is vacated. In order to comply with the provisions of SB 1953, the H-UCLA Master Plan responds to the need to replace the existing patient tower by January 1, 2030. The Master Plan designates a location for the proposed replacement building, such that it can be connected with the new Surgery/Emergency Building, which opened earlier this year. As part of the development of the new building, the Master Plan identifies the need to demolish numerous existing buildings and surface parking lots to create space for the needed parking structures, central plant, and outpatient and inpatient facilities. To provide adequate space for the new tower, outpatient services should be consolidated into new facilities on or about 2021 and a new parking structure should be completed as a first phase on or about 2017.

An Environmental Impact Report (EIR) is currently underway for the Master Plan project, and is expected to be completed by Summer 2015. In October 2014, recommendations will be presented for Board approval to award a consultant contract to Perkins + Will to complete time-critical pre-design work necessary to meet the proposed schedule for opening the new patient tower.

Further, it should be noted that the Master Plan assumes that the replacement facility would include the same number of patient beds as the existing hospital. The plan to assess the need for additional inpatient beds countywide will help to confirm whether that is the correct assumption for planning the new hospital.

Operating Costs – A programmatic assessment was completed as part of the master planning process, including an assessment of projected inpatient bed needs and bed types. This programmatic assessment recommended no substantial change in the total number of beds at H-UCLA (i.e., recommendation was for 446 beds). The programmatic assessment, however, does recommend a right-sizing of the types of beds relative to the current configuration (e.g., additional critical care beds; fewer obstetrics and pediatrics beds). This right-sizing will require an adjustment in the cost structure wherein increases in one area will be either entirely or mostly offset by reductions in other areas. H-UCLA's EIR is currently underway and expected to be completed and presented to the Board by Summer 2015. This information will ultimately determine the costs of operating a new H-UCLA.

Based on the assumption that the replacement H-UCLA hospital would have the same number of beds as the existing facility and comparable service capabilities, DHS anticipates the cost structure would be the same with no additional funding requirements. Any sizeable changes to the programmatic plan, bed mix, number of beds, or recommended changes in ancillary or outpatient services would have an impact on the anticipated operating requirements.

Subject to the Board's desire, DHS can seek funding to work with DPW to begin the planning and design process for both projects, now or upon acceptance of the complete Campus Master Plan/EIR.

2. POTENTIAL FUNDING SOURCES FOR THE CAPITAL CONSTRUCTION AND ONGOING OPERATIONS RESULTING FROM CAPITAL PROJECTS EXPANSION AT EACH OF THESE FACILITIES

Given the estimated value of the LAC+USC and Harbor-UCLA capital projects, the most viable source of funding for these projects is long-term bond financing.

The potential funding sources for ongoing operations, to the extent they are higher than existing operational costs currently covered in the DHS budget, and the debt service on the capital construction long-term debt are:

- Additional patient revenues from increases in service volume resulting from expanded service capability;
- Additional patient revenues from an increase in the number of patients who have coverage due to the ACA;
- Increased Waiver revenue, depending on the terms and conditions of the new Waiver; and
- Increased County contribution above the AB 85 MOE.

3. THE IMPACT OF THESE CAPITAL PROJECTS EXPANSIONS ON THE EXISTING MOE BETWEEN DHS AND THE STATE OF CALIFORNIA

One of the components of the AB 85 agreement between the County and the State is an MOE. The MOE establishes a minimum annual level of funding the County is required to contribute to DHS. The AB 85 agreement with the State does not preclude the Board from contributing additional funding above the MOE minimum to DHS.

In addition to the MOE, the AB 85 agreement also includes an annual Cost Cap on DHS. The Cost Cap calculation exempts cost increases for capital project costs incurred to meet seismic requirements. However, expenditures for capital projects, including the debt service on these projects, that are not seismic-related will impact the Cost Cap.

4. THE IMPACT OF THE ACA IMPLEMENTATION ON UTILIZATION RATES AT ALL COUNTY HOSPITALS

A major component of the ACA was the implementation of the Medicaid expansion and health insurance exchanges on January 1, 2014. California led the nation in early implementation of the Medicaid expansion portion of the law through its Section 1115 Medicaid Waiver "The Bridge to Reform", which allowed for the creation of County-specific Low Income Health Programs (Healthy Way LA in Los Angeles County). These events could be expected to impact inpatient utilization at County hospitals in three primary ways.

a. **Attraction and retention of newly insured patients**: The rapid shifts in coverage as a result of the implementation of the ACA present opportunities for DHS to gain or lose volume from newly insured. Such shifts will depend on the success of a number of initiatives, including securing commercial or managed Medi-Cal contracts for specialty and inpatient care, attraction of patients who are new to Medi-Cal or who are dually eligible for Medi-Cal and Medicare, and retention of Medi-Cal patients among those who are new to coverage. These factors will have a major impact on the overall demand for inpatient beds within the County public hospital system over the coming years. Early data from the roll-out of the ACA indicates success in this area, with approximately 267,000 Medi-Cal enrollees assigned to DHS medical homes, with enrollment increasing by an average of 6,700 individuals every month. We will monitor this data closely given the substantial impact it has on demand for system resources, including inpatient capacity.

b. **Repatriation of assigned Medi-Cal patients**: With the expansion of Medi-Cal, DHS has a greater number of assigned lives for whom it is financially responsible for their care, including costs incurred by out-of-network inpatient admissions. As a result, it is in

DHS' best interests to "repatriate" or transfer many of these patients back to DHS, increasing the number of potential admissions and raising the overall demand for beds in the DHS system. Recent data demonstrates that in the first six months of 2014, there were nearly 5,000 admissions in non-DHS hospitals by Medi-Cal patients who were assigned to DHS. Of these, 300 were presented to DHS for transfer and 203 (68 percent of those presented; 4 percent of total admissions) were actually repatriated to DHS. Data from 2013 represent a similar trend[a]. While a majority of patients admitted out of network will not be candidates for transfer (e.g., unstable for transfer; anticipate rapid discharge), DHS would make a greater effort to increase the number of patients repatriated to in-network hospitals if sufficient beds were available to do so.

c. **Pent-up demand**: It is commonly presumed that newly insured individuals will increase their utilization of health care services due to a greater perceived access to care and a desire to obtain services for problems they previously did not seek care for. While such a trend has been observed in states implementing coverage expansions, the finding is time-limited. For example, as seen with Oregon's Medicaid expansion program, coverage was associated with a 30 percent increase in the probability of having a hospital admission one year after obtaining coverage[b]. By the second year of the program, however, there were no significant changes in ED visits or hospital admissions compared to the baseline year[c], signifying that people's demand for services had equalized close to the prior level of utilization.

As seen in the chart below, to date, DHS has not seen a substantial change in inpatient utilization over the first six months of full ACA implementation. Future trends in inpatient utilization will depend on the factors listed above, particularly success in repatriating patients admitted to out of network facilities, and attraction and retention of managed Medi-cal patients via assignment of primary care lives and via specialty contracting initiatives.

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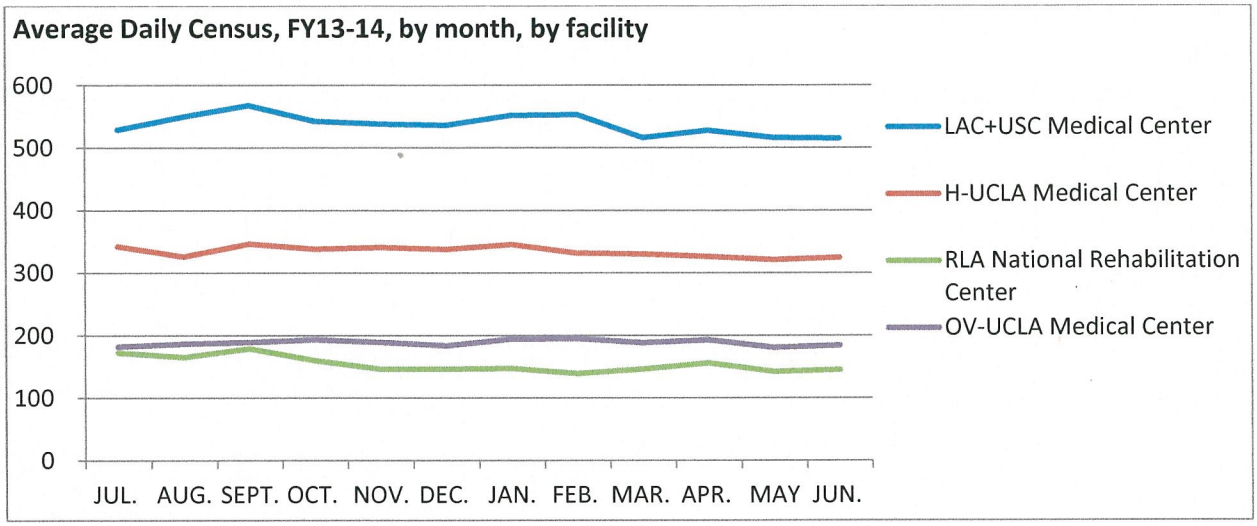
[a] For Calendar Year (CY) 2013, there were nearly 6,000 total out-of-network admissions; 421 patients presented for transfer to DHS, and 252 actual transfers. Data includes Medi-Cal only; HWLA patients not included.

[b] Finkelstein A et. al. The Oregon health insurance experiment: evidence from the first year. Q J Econ. 2012. 127(3):1057-1106.

[c] Baicker K et. Al. The Oregon experiment—effects of Medicaid on clinical outcomes. N Engl J Med. 2013. 368(18): 1713-1722.



5. A PLAN TO ASSESS THE NEED FOR ADDITIONAL INPATIENT BEDS COUNTYWIDE BY BED ALLOCATION (E.G., MEDICAL/SURGICAL BEDS, TELEMETRY BEDS, STEP DOWN BEDS, PSYCHIATRY BEDS, ETC.) INCLUDING THE MLK SERVICE AREA

DHS hospitals' current inpatient capacity and utilization, by licensed bed type, is below.

H-UCLA

Licensed Beds By Classification	# of Licensed Beds	# of Staffed Beds (Budgeted)	ADC for FY 13-14	Occupancy Rate
Intensive Care	44	42	37	88%
Perinatal	29	20	11	55%
Intensive Care Newborn Nursery	27	21	16	76%
Pediatric	25	24	15	63%
Acute Respiratory Care	8	0	0	0%
Coronary Care	6	6	5	83%
Renal Transplant	6	6	4	67%
Unspecified General Acute Care	270	240[d]	205	85%
Sub-total: Med/surg	**415**	**359**	**293**	**82%**
Acute Psychiatric	38	38	35	92%
Total	**453**	**397**	**328**	**83%**

[d] 12 beds used as telemetry; 81 beds used as step-down

LAC+USC

Licensed Beds By Classification	# of Licensed Beds	# of Staffed Beds (Budgeted)	ADC for FY 13-14	Occupancy Rate
Intensive Care	130	130[e]	102	78%
Intensive Care Newborn Nursery	40	40	18	45%
Perinatal	32	32	29	91%
Pediatric	25	25	10	40%
Burn	20	20	11	55%
Coronary Care	10	10	9	90%
Unspecified General Acute Care[f]	343	343[g]	299	87%
Sub-total: Med/surg	**600**	**600**	**478**	**80%**
Acute Psychiatric	76	65	59	91%
Total	**676**	**665**	**537**	**81%**

Olive View-UCLA Medical Center (OV-UCLA)

Licensed Beds By Classification	# of Licensed Beds	# of Staffed Beds (Budgeted)	ADC for FY 13-14	Occupancy Rate
Intensive Care	42	30[h]	27	90%
Perinatal	29	8	5	63%
Pediatric	18	4	1	25%
Intensive Care Newborn Nursery	14	6	7	117%
Unspecified General Acute Care	200	127[i]	110	87%
Sub-total: Med/surg	**303**	**175**	**150**	**86%**
Acute Psychiatric	52	32	31	97%
Total	**355**	**207**	**181**	**87%**

Rancho

Licensed Beds By Classification	# of Licensed Beds	# of Staffed Beds (Budgeted)	ADC for FY 13-14	Occupancy Rate
Intensive Care	24	4	5	125%
Unspecified General Acute Care	115	106	72	68%
Sub-total: Med/surg	**139**	**110**	**77**	**70%**
Acute Rehabilitation	150	79	77	97%
Total	**289**	**189**	**154**	**81%**

In interpreting the capacity and occupancy data listed above, several issues, categorized by broad bed type, should be kept in mind.

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[e] 10 beds used as step-down
[f] Includes 24 jail beds with ADC of 17
[g] 16 beds used as telemetry
[h] 12 beds used as ICU beds; 18 beds used as step-down
[i] 6 beds used as step-down; 24 used as telemetry

- **High-acuity bed types – telemetry, step-down, and intensive care unit (ICU)**: Capacity and occupancy rates of each facility's telemetry and step-down beds are provided below.

Telemetry and Step-down Capacity & Occupancy Rate, FY13-14

	Telemetry		Step-down	
	Staffed Capacity	Occupancy Rate	Staffed Capacity	Occupancy Rate
H-UCLA	12	>85%	81	>90%
LAC+USC	16	>95%	10	>95%
OV-UCLA	28	>95%	24	>95%

The high utilization rates seen in DHS' telemetry and step-down beds is understandable given the fact that DHS has a disproportionately low share of these bed types. To address this, DHS has recently added, and plans to continue to add, additional bed capacity in these areas. For example, in 2012, LAC+USC added monitoring functionality to convert 16 medical/surgical beds into telemetry beds, and transitioned 10 beds to serve as the facility's first step-down unit. At OV-UCLA, DHS plans to request an additional 6 step-down beds in the FY 2015-16 Recommended Budget. This relative shortage of step-down and telemetry beds increases ICU occupancy rates because patients must remain in the ICU until they can be safely transferred to the next lowest available level of care. The addition of telemetry and step-down capacity will thus alleviate pressure on the ICUs and free up capacity for patients in need of this highest level of clinical care.

- **Psychiatry**: The occupancy rate on inpatient psychiatric units consistently exceeds 90 percent. This, combined with high censuses in the psychiatric emergency rooms and associated long wait times for admission, may be interpreted as a need for additional inpatient beds across the DHS system. However, data has consistently shown that approximately half of patients occupying inpatient psychiatric beds are awaiting placement in a lower level of care, as evidenced by combined administrative day and denied day[j] rates that typically exceed 50 percent. Given this, DHS recommends that any additional capital and operating dollars available for mental health services be spent on building up lower-cost out-of-hospital capacity for patients who are ready to be discharged from inpatient psychiatric units, rather than spending these funds on building and/or staffing additional inpatient psychiatric units. This strategy would result in more efficient use of newly available funds and would also make best use of existing funds

[j] There are multiple reasons for denied days, many, but not all, of which are due to lack of available capacity in lower level of care placements that are not eligible for administrative day payments. Other reasons for denied days include inadequate documentation by providers, etc.

allocated to mental health by ensuring that patients hospitalized on costly and restrictive inpatient psychiatric units are appropriate for that level of care.

- **Sub-specialty units**: Occupancy rates are below the targeted 80 percent[k] across a number of specialty and sub-specialty units at DHS. Certainly, the best solution to this problem is to increase volume in the affected specialty, for example, through execution of additional contracts with commercial or Medi-Cal providers; DHS has recently executed a number of such contracts and expects a positive result of these activities. Beyond efforts to increase inpatient utilization, it has been suggested that low occupancy rates present an opportunity for consolidation or rationalization of service offerings across the DHS system. While this would help to leverage economies of scale, improve efficiency, and may help enhance quality by consolidating low-volume services[l], any potential reorganization must be carefully considered. For example, due to the requirements of State and federal regulatory agencies, and the functional requirements of residency training programs, facilities often must maintain a specific minimum number of beds by specialty area. While rules vary widely by specialty program, reductions below this number may compromise training opportunities, certifications, and reimbursement. Further, patients also often prefer to have multiple services available in one setting, and may be less likely to use a facility that does not provide a comprehensive set of services covering the full continuum of care. DHS will continue to evaluate the success of external contracting efforts and the potential wisdom of various consolidations. Any preliminary recommendations would be brought to the Board for full discussion.

In addition to continuing to assess inpatient occupancy rates over time, DHS will also regularly monitor trends in the large number of factors that affect demand for inpatient beds within the DHS system. As described in response number four above, health reform has the potential to significantly affect inpatient bed utilization, either upward or downward. These ACA-related factors have the potential to have the most impact on overall bed demand. Beyond these ACA-associated issues, DHS will also pay attention to a number of additional factors that will also impact inpatient hospital utilization moving forward. These are briefly described below:

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[k] 80% is a commonly used target for inpatient beds with a high rate of turnover (i.e., med/surg, ICU). Units with lower turnover can operate efficiently at slightly higher occupancy rates (e.g., 85-90%).

[l] Quality gains are possible for a number of reasons: the ability of higher-volume hospitals to attract higher caliber staff, reduction in errors/improvement in outcomes in high-volume centers, etc.

Non-ACA-related factors that may drive greater demand for additional inpatient beds:

a. **Population Growth**: The total population of Los Angeles County is projected to grow by 6.3 percent from 2010 to 2020[m]. Based on an average bed utilization of 454 days per 1,000 population[n], this would lead to an overall increase in inpatient bed demand of approximately 770 beds assuming other factors are held constant.

b. **Aging population**: Use of hospital services increases significantly as people age: In California, those aged 60 and over had 124 percent more discharges than other age groups[o] (787 discharges per 1,000 for those aged 60 and over vs. 351 discharges per 1,000 population for all other groups combined). The number of Californians aged 65 and over is projected to increase by 38 percent between 2010 and 2020[p]; this increase in the number of elderly will also increase the overall demand for inpatient beds.

c. **Perception/Equalization of Emergency Department (ED) wait times**: A positive, significant relationship exists between hospital bed availability and hospital utilization rates[q]. There are a number of potential explanations for this finding, one of which is that patients are more likely to go to hospitals with shorter ED wait times, with ED wait times being one general indicator of available bed capacity. Current wait times in the DHS system, see data below, are longer than those in many surrounding hospitals. Because of this, it is likely that some patients may choose to bypass a DHS hospital in favor of another facility with shorter wait times and more available beds. The significance of this is that once additional capacity is built, helping to reduce long ED waits, additional patient volume may come which will help to fill the newly available inpatient beds. This supplier-induced demand is difficult to quantify but could have a sizeable effect on overall inpatient demand at County facilities.

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[m] State of California, Department of Finance. Report P-1 (Age): State and County Population Projections by Major Age Groups, 2010-2060. Sacramento, California, 2013.

[n] Hospital inpatient days per 1,000 population, California, 2010. Source: Kaiser Family Foundation. 2013. Data from http://kff.org/other/state-indicator/inpatient-days/

[o] California Healthcare Foundation. California hospitals: buildings, beds and business. 2013.

[p] State of California, Department of Finance, 2013.

[q] Delameter PL et al. Do More Hospital Beds Lead to Higher Hospitalization Rates? A Spatial Examination of Roemer's Law. PLoS ONE, 2013. 8(2): e54900.

ED Wait Time and Boarding Time by Facility, August 2014

	Median ED Length of Stay[r]	Median ED Boarding Time[s]
H-UCLA	8h 29m	4h 12m
LAC+USC	9h 41m	4h 38m
OV-UCLA	6h 9m	4h 15m

Non-ACA-related factors that may lessen demand for additional inpatient beds:

a. **Evolution of patient care**: Advances in technology have increased the use of less-invasive procedures, a major factor in supporting an ongoing shift from inpatient to outpatient care. Between 1981 and 2005, the number of outpatient surgeries grew from 3.7 million to over 32.0 million, while outpatient procedures represented over 60 percent of all surgeries in the United States (U.S.) in 2011 (compared to just 19 percent in 1981)[t]. This is a major factor in the overall decline in hospital admissions in the U.S[u].

b. **Implementation of patient-centered medical homes (PCMH)**: Coordinated and continuous medical care for patients with chronic illnesses has the potential to maximize health outcomes and reduce the number of preventable hospitalizations, reducing the overall demand for inpatient hospitalizations. However, evaluations of the PCMH model thus far have been mixed: a recent review article spanning 19 comparative studies on medical home interventions found that the PCMH model reduced emergency department visits, but had no significant impact on hospital admissions[v]. It will be important to continually assess the impact of different PCMH structures on the demand for inpatient services.

c. **Emphasis on inpatient efficiency**: Improvements in inpatient operations and discharge practices resulting in declines in length of stay (LOS) will increase a facility's overall bed availability allow it to serve more patients. Each DHS facility has a number of initiatives underway to improve inpatient operations. The success of these initiatives, as measured in LOS metrics, could lessen the need to build additional inpatient capacity and will allow DHS to see more patients within its existing resources.

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[r] Time from arrival in the ED to physical departure; all adult medical patients.

[s] Time from an admission decision by attending physician to physical transfer to an inpatient bed; all admitted adult medical patients.

[t] Munnich et al., Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up. Health Affairs, 2014. 33(5): 764-769.

[u] Total inpatient admissions for U.S. hospitals fell from 35.76 million in 2008 to 34.40 million in 2012. Source: AHA

[v] Jackson GI et al. The patient-centered medical home: a systematic review. Annals of Internal Medicine. 2013. 158(3):169-178.

Finally, external market forces can affect demand for inpatient beds at DHS, pushing demand either higher or lower. Such factors include private hospital closures, new private hospital construction, health plan reimbursement rates to private providers affecting their likelihood of accepting Medi-Cal patients, etc.

Moving forward, DHS will continue to monitor trends in occupancy and census data in DHS hospitals. Facility-level data of this type is already followed regularly on the DHS dashboard. This and more detailed data captured by bed-type will be continuously tracked. In addition, DHS will monitor trends in factors that affect demand for inpatient beds within the DHS system with particular attention to the ACA-related factors that will have the most impact on overall bed demand. We will plan to report this data regularly to the Board on an ongoing basis.

Martin Luther King Jr. Community Hospital

Located in Service Planning Area 6 (SPA 6), the 131-bed Martin Luther King, Jr. Community Hospital (MLKCH) will provide inpatient services to the communities of South Los Angeles upon its anticipated opening in Summer 2015. Currently, licensed bed capacity in SPA 6 trails the rate across Los Angeles County and California overall[w], indicating a relative unmet need in that region for inpatient beds. With this relative shortage of beds, patients who reside in South Los Angeles who require emergency or inpatient services often travel to facilities outside of their community for care, or, more critically, may delay or avoid seeking care until they are acutely ill. This tendency is associated with two main problems. First, delays in seeking patient care may lead their condition to progress to a level of acuity in which they require more intensive services, at higher cost, and with the potential for greater long-term morbidity. Second, traveling to more distant facilities may pose a substantial inconvenience or even hardship for patients, considering such things as the cost of travel, time taken off work, time away from family, less frequent visitors if admitted, need to go to follow-up outpatient visits at the site of an admission, etc. Once MLKCH is open to patients, South Los Angeles will serve as another option for patients seeking high quality patient care in their community. It is likely that many patients that currently seek care outside of South LA will choose to utilize MLKCH as their ED and inpatient facility of choice, avoiding the adverse consequences outlined above.

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[w] Licensed general acute care beds per 1000 population = 2.7 in LA County vs. 1.2 in the 5 mile radius around MLKCH. Sources: OSHPD Hospital Annual Financial Report FY 2012-2013 and 2013 Population Estimates, prepared for LA County ISD by Hedderson Demographic Services, released 4/1/2014.

Any additional capital expenditures dedicated to inpatient capacity expansion within the County public hospital system should be guided by continued assessments of both the unmet need for inpatient beds within a community and actual demonstrated demand for beds as indicated by patient volume and actual workload statistics. Specifically with respect to South Los Angeles, given the relatively low number of inpatient beds in the area surrounding MLKCH, DHS will closely monitor occupancy rates in the years following the opening of the new facility to assess actual demand for services and determine whether it would be prudent to invest in additional inpatient capacity at that site.

6. A STATUS REPORT ON EFFORTS TO ESTABLISH A TRAUMA CENTER IN THE EAST SAN GABRIEL VALLEY

On April 1, 2014, DHS released a Request for Information (RFI) for Trauma Service Center Candidates in the East San Gabriel Valley (ESGV). The RFI was sent to all hospitals in the region capable of being designated as a trauma center in the near future. The deadline for submitting the RFI was April 16, 2014, which was extended to the end of May 2014 at the request of two hospitals in the ESGV. DHS received two responses and determined a competitive solicitation was necessary to elicit sufficient information from the respondents to formally evaluate the responses and select one entity to negotiate a contract with. DHS issued a Request for Applications (RFA) on August 27, 2014 with a due date of October 1, 2014, which was extended to November 19, 2014 at the request of the applicants. After an evaluation process, one entity is expected to be selected with contract negotiations commencing in early December 2014. The timeline for establishing a trauma center in the region will depend on the readiness of the selected hospital.

If you have any questions or need additional information, please contact me or your staff may contact Gregory Polk at (213) 974-1160 or via e-mail to gpolk@ceo.lacounty.gov or Christina Ghaly at (213) 240-7787 or via e-mail to cghaly@dhs.lacounty.gov.

WTF:GP
MM:hd

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County Counsel
Health Services
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